

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2014
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of 2 State hospital complaints.</p> <p>Complaint: #IN00138510-Substantiated; No deficiencies related to the allegations are cited. #IN00119291-Substantiated; No deficiencies related to the allegations are cited.</p> <p>Survey Date: 4/30/14</p> <p>Facility #: 005051</p> <p>Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>Indiana University Health is in compliance with 410 IAC 15-1.5-1, Dietary services, 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing services, 410 IAC 15-1.5-7, Pharmaceutical services, 410 IAC 15-1.6-1, Anesthesia services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 05/12/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE